

EMPLOYABILITY ASSESSMENT REPORT (EAR)

Employer _____		Account ID _____	Claim Number: _____
Injured Worker's Name: _____			
Vocational Referral:	<input type="checkbox"/> Vocational Assessment	<input type="checkbox"/> Medical Instability	
Explanation: _____			
Anticipated Date for the Employability Decision _____			

Self-Insurer's Notification:

Check only one eligibility status and the single best reason for your conclusion based upon the availability of objective information.

- A. ☐ Eligible for vocational services.
- B. ☐ Able to work.
1. ☐ Worker returned to work on ____/____/____ in a permanent job and condition is stable.
Priority # _____
2. ☐ Worker can work based on transferable skills.
- C. ☐ Not eligible for vocational services due to one of the following:
- 1 ☐ Pre-existing and progressive condition(s)/unrelated to this claim.
 - 2 ☐ Post conditions/unrelated to this claim.
 - 3 ☐ Direct effects of the industrial injury.
 - 4 ☐ Combined effects (second injury)
 - 5 ☐ Worker's actions.

VR Provider ID: _____		Branch Number: _____		VR Provider Name: _____	
VRC Name: _____		VRC ID: _____		VRC Phone Number: _____ ()	
VRC Address: _____		City: _____		State: _____ ZIP+4 _____	
Injured Worker's Name: _____		Injured Worker's Phone #: _____ ()		Date of Injury: _____	
Injured Worker's Address: _____		City: _____		State: _____ ZIP _____	
Legal Representative's Name: _____				Legal Rep's Phone Number: _____ ()	
Legal Representative's Address: _____		City: _____		State: _____ ZIP _____	
Attending Physician's Name: _____		Attending Physician's Phone Number: _____ ()		VR Referral Date: _____	
Attending Physician's Address: _____		City: _____		State: _____ ZIP _____	
Employer or Service Representative's Signature: _____				Phone No. _____	
				Date: _____	

NOTE:

☐ File Attached ☐ File Previously Sent

All medical reports and other pertinent information in the Self-Insurer's possession not previously forwarded to the Department must be submitted with this request (WAC 296-15-070).

For Internal Use Only:	<input type="checkbox"/> Approved	<input type="checkbox"/> Disapproved	<input type="checkbox"/> Unable
Date: _____ Signature: _____			

EMPLOYABILITY ASSESSMENT FORM INSTRUCTIONS FOR THE SELF-INSURER

Purpose:

Rule requires the self-insurer to submit an Employability Assessment Report (EAR) no later than paying 90 days of continuous time loss after the filing or re-opening of the claim and if a vocational referral is not being made or if an extension of time is not necessary.

The primary purpose of the self-insurer's EAR is to notify the Department of an injured worker's employability status. **Objective reasons for the determination must be provided.**

DETERMINATION INFORMATION REQUIREMENTS:

The following lists what supporting documentation is required with the EAR.

<u>Determination:</u>	<u>Information Requirement:</u>
A. Eligible for vocational services	Employability Assessment Report
B. Able to work	
1. Return to Work (Currently working in similar work pattern as the time of injury)	
Priority Codes Definitions	
a. Return to the previous job with the same employer,	Full duty work release or job
b. Modification of the previous job with the same employer including transitional return to work,	analysis signed by a physician or majority of medical opinion.
c. A new job with the same employer in keeping with any limitations or restrictions,	
d. Modification of a new job with the same employer including transitional return to work,	
.....	
e. Modification of the previous job with a new employer,	Job analysis signed by a
f. A new job with a new employer or self-employment based upon transferable skills,	physician, majority of medical opinion or any other substantive documentation.
g. Modification of a new job with a new employer,	
h. A new job with a new employer or self-employment involving on-the-job training,	
i. Short-term retraining and job placement.	
2. Worker can work based on transferable skills or has full release but is not working.	Employability Statement Form (ESF) and Claim File duty
C. Not eligible for vocational services	
1. Pre-existing and progressive condition(s)/unrelated	Appropriate Expert Opinion & Claim
2. Post condition(s)/unrelated	File for each category
3. Direct effects of the industrial injury	
4. Combined effects (second injury)	
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5. Worker's actions	Supporting documentation for a long term pattern of minimal compliant behavior

NOTE:

It is the responsibility of the Employer or Service Company to submit the EAR and any attachments, including the ESF, to the Department with copies to the injured worker.